March 16, 2012

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

Re: Notice of *Ex Parte* Communication, WC Docket No. 02-60

Dear Ms. Dortch:

On February 21, 2012, representatives of three projects in the FCC's Rural Health Care Pilot Program (RHCPP) spoke via telephone with Linda Oliver, Christianna Barnhart, and Chin Yoo of the Wireline Competition Bureau. These representatives were Brian Bickel, CEO, Southeastern Arizona Medical Center and a principal of the Arizona Rural Community Health Information Exchange; Hale Booth, Executive Vice President, BrightBridge, Inc. and Associate Project Coordinator, Erlanger Health System; and Ernestine Howard, Chief Financial Officer, Kentucky River Community Care and Project Coordinator, Kentucky Behavioral Telehealth Network. The purpose of the call was to discuss the telecommunications needs of rural health care providers (HCPs) in response to the Commission's July 15, 2010 Notice of Proposed Rulemaking in the above-referenced docket. The pilot project participants discussed some of the current or expected benefits that broadband had brought to their projects, and discussed what worked or could be improved in the application and implementation process. They made the following points in their discussion:

Availability and affordability of broadband. Broadband connections simply aren't available in many rural areas. Often all that is available is a T-1 circuit, or multiple T-1s. The pilot program provided funding to bring fiber to many rural hospitals that otherwise would have only T-1s. As Mr. Booth noted, many rural hospitals that have only a T-1 don't realize what they are missing; once they have the larger bandwidth connections, they immediately see what more they can do. The RHCPP subsidies also have made broadband affordable for many health care providers who otherwise would have difficulty even paying for a T-1. At least two of the projects found that once the fiber connection is in place, HCPs can get a great deal more bandwidth for not much more money. In the Arizona project, the monthly internet access bill for 7 bonded T-1s (approximately 10 MB of bandwidth) was almost $10,000 – and even then, reliability was often a problem. The pilot project enabled a DS-3 connection (approximately 45 MB of bandwidth) at $2,000 a month with the 85% discount (providing over three times the capacity for not much more than the rate for the 7 bonded T-1s, even without the discount). In Kentucky, the discounted rate for a 45 Mbps connection is close to what KBTN was paying for a T-1 ($400-500 per month), or a thirty-fold increase in bandwidth.

Affordability Challenges. The participants pointed out the real need for the FCC's rural health care program given the high cost of broadband connections. Even with the FCC's subsidies, the cost of broadband connections creates challenges for rural health care providers, whose operating margins are very thin. Without funding for administrative expenses, it is hard to find funding to pull together a network of eligible HCPs, develop the proposals, and pursue the application process, especially given the cash-strapped position of many rural health care providers. Projects often found it difficult to come up with funding for administrative expenses or for the required 15% HCP match.

Role of urban sites. Pilot projects were able to link rural hospitals and rural health clinics with the urban hospitals that already were providing tertiary care (specialist care) to patients in those rural areas, facilitating telemedicine and other telehealth services. Rural hospitals can move from a "patch and

ship" mode to keeping their patients in the rural hospital and consulting specialists remotely, which is better for patients and helps rural hospitals financially. In Kentucky, the hope is to access psychiatrists in urban areas when all the community mental health centers are up and running.

Telehealth applications. Mr. Bickel noted that technology is already available to provide such telemedicine services as telepharmacy, telestroke, teledermatology, and telecardiology. All of the teleradiology services for his rural locations are provided from Phoenix. In Tennessee, many telemedicine applications are available. Erlanger is a leading telestroke center; remote hospitals and clinics are interested in telepsychiatry and telepharmacy, for example. Mr. Booth said that it is best to let the rural HCPs figure out what they need in the way of telemedicine services, once they have the broadband capability. Ms. Howard explained that the Kentucky project includes facilities in very rural areas with limited access to psychiatry providers, and the community mental health providers will be examining ways to share those resources (psychiatry providers) through their network. Ms. Howard also observed that continuing medical education and other care-driven training is an important application for broadband. Mr. Booth observed that demand for bandwidth is rapidly increasing, for the exchange of medical records and scans, including high definition images, and for video consults.

Administrative obstacles. The participants made note of a number of ways in which they experienced confusion about the rules and limitations of the RHCPP. This confusion resulted in significant delay for some projects, and increased their administrative costs. Some examples they cited: (1) confusion regarding eligibility of administrative expenses, because grant programs often include that funding; (2) confusion regarding eligibility of rural health care sites; (3) confusion about allowable purposes for the network; and (4) mistaken assumptions about eligibility for funding of software costs associated with Health Information Exchanges and other telehealth applications. The participants stressed the importance of clarity in the rules regarding eligibility, the procedural requirements, and other elements of the program. One suggested that the requirements be written in "plain English."

Role of coaches. The projects for the most part found the coaches provided to help with the application process to be essential and generally knowledgeable and helpful. They were not always able to help parse the rule requirements or to resolve confusion mentioned above, and that better training and guidance to coaches would have helped. In some cases, the coaches were changed during the project application process, which caused delay and confusion.

Other sources of project delay. The recession has had a negative impact on the revenues of rural hospitals and other rural health care providers. In Tennessee, for example, plant closures caused a reduction in revenues for several rural hospitals and required some reorganization. For some projects, it took quite some time to come up with funding sources for administrative expenses or for the 15% match. For Kentucky, the project experienced significant delays due to the need to obtain necessary rights-of-way and other permits to be able to string fiber. In the case of the Arizona project, the distractions of setting up a health information exchange (HIE), and changes from regional to statewide approach to HIE. There also was confusion initially regarding whether HIE software costs were covered by the pilot program. Similarly, in Kentucky, the state went to managed care for Medicaid patients very quickly, effective November 1, so for a while the focus was taken away from implementing the pilot project.

Other obstacles to telehealth. Lack of funding sources for subscription fees and software may delay adoption of electronic health information exchanges. Mr. Bickel said that in Arizona, for example, the annual subscription fee can run from $10-15,000 to as much as $250,000. Mr. Bickel also pointed out that technological capabilities for telemedicine had bypassed regulation long ago – and that regulatory impediments are holding up many telemedicine applications.

Differences between "primary" and "pilot" programs. The participants also discussed differences between the FCC's "primary" rural health care program, which funds the differential between urban and rural rates, and the pilot program. They observed that the urban/rural differential is of no use if the facilities are not available. The participants believed that the pilot program helped prompt the deployment of fiber or other high capacity facilities to many HCP sites where such facilities were not previously available. The participants pointed out, however, that health care providers don't want to own the telecommunications network facilities. They agreed that ownership of newly constructed facilities only makes economic sense where there are gaps in availability. In some locations, fiber owned by utility companies can be used for rural health care purposes. In Tennessee, Erlanger was able to leverage the fiber belonging to nonprofit electrical companies, who were willing to share it with Erlanger for use in its health care network.

Respectfully submitted,

/s/
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